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Pathways to Your Benefits 2005

Each day we confront challenges, make decisions, and choose particular pathways to follow. In retirement, those pathways may be familiar or they could offer exciting new opportunities. To help you create a successful retirement for you and your family, the County is proud to provide you with a competitive retiree medical program – Pathways to Your Benefits.

We know that your benefits are important to you and your whole family. We also know that you need tools and resources to help you take advantage of all your coverage has to offer. This enrollment guide is designed to help you take the first steps down the pathways to your benefits – understanding and choosing your benefits for the coming year. Inside you'll find details about the County Retiree Medical Insurance Program (RMIP) and eligibility, as well as enrollment deadlines and where to go for additional information. Take some time to read through this guide carefully and share it with your family. Then you'll be ready to make the decisions that are right for you and your family.

What's New for 2005?

We would like to inform you that effective January 1, 2005, there will be changes to all of the County's health plans. The following is an outline of the changes to the County's health plans for 2005.

PPO Health Plans: Premier Wellwise and Premier Sharewell

- Elimination of the Premier Preferred Choice health plan
- New Claims Administrator, PacifiCare Health Plan Administrators will replace Delta Health Systems
- New PPO Network through PacifiCare Health Plan Administrators
- Premier Wellwise annual deductible increases from $200 to $300 per individual and a $600 maximum per family
- Premier Wellwise: All prescriptions must be purchased through the Caremark Prescription Drug Card and Mail Order program. Prescriptions obtained as a result of an emergency must be filed with PacificCare, the PPO claims administrator.

HMO Health Plans: Cigna, Kaiser and Kaiser Senior Advantage

- Office visit co-pay increases from $5 to $15
- Prescription co-pays increase from $5 to $10 for generic drugs and from $5 to $15 for brand name drugs
- Add an Inpatient Hospital deductible of $100 per admission
- Increase the Emergency room co-pay to $50, waived if admitted

2005 Health Plan Rates

PPO Plans: Premier Wellwise and Premier Sharewell
Rates for 2005 for the two PPO plans are increasing. Please refer to your personalized Benefits Enrollment Summary for specific rate information. The Benefits Enrollment Summary will be sent to your home address.

HMO Plans: CIGNA and Kaiser
Rates for 2005 for the two HMO plans are decreasing. Please refer to your personalized Benefits Enrollment Summary for specific rate information. The Benefits Enrollment Summary will be sent to your home address.

Time to Enroll

This year's Open Enrollment period will be from Monday, November 1 through Friday, November 26, 2004. Benefit Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Standard Time, except holidays.

If at all possible, we encourage you to enroll before Friday, November 26, so that you're not up against the deadline or "waiting in line" to speak with a Benefits Specialist.

The benefits you elect during Open Enrollment will be effective January 1 through December 31, 2005.

Remember, all you have to do is click or call. Just log on to the Benefits Center Web Site or call the Benefits Resource Line and speak to a Benefits Specialist to enroll.

If You've Got Questions, We've Got Answers

If you have questions about Open Enrollment, you can visit the Benefits Center Web Site at ***www2.benefitsweb.com/countyoforange.html*** or call the Benefits Resource Line toll-free at 1-866-325-2345 and follow the instructions to speak with a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Standard Time, except for holidays. If you need assistance in another language, Benefits Specialists can connect you with a translation service at no cost to you. For TDD communication services for the hearing impaired, call toll-free at 1-800-TDD-TDD4 (833-8334).

What to Do Now

- Read this Enrollment Guide carefully to understand how your benefits package works.
- Review the materials enclosed in your enrollment package, including:
  - **Benefits Enrollment Summary** — This summary contains your Personal Identification Number (PIN), information about the benefits available to you in 2005, and your contributions. It also shows your automatic benefits coverage for 2005.
  - **Open Enrollment Meeting Schedule** — To help explain your Open Enrollment options, we have set up a series of meetings to review your benefit options. Find a date, time, and location that is convenient for you to attend. Your attendance is strongly recommended.
  - **Wallet Card** — This card includes important phone numbers and web sites and basic instructions on how to use the Benefits Center Web Site and Benefits Resource Line to enroll.
- Enroll for your benefits before the November 26, 2004 Open Enrollment deadline.

If You're a Current Retiree

If you're currently retired and you want to keep the same retiree health plan and dependents as shown on your Benefits Enrollment Summary, you do not need to enroll. However, ***you must enroll if you want to***:

- Add or drop dependents from coverage
- Change your retiree health plan
- The coverage shown on your Benefits Enrollment Summary *is* how you will be enrolled if you do not make any changes within the stated deadline. Review it carefully and within the required timeframes, including the dependent coverage section, as no changes can be made after the deadline.

Once you receive your Confirmation Statement you must report any errors within 10 business days from the date on the statement.

Keep in mind that after the Open Enrollment period, you can't change your benefit elections during the year unless you have a life event. See Making Changes to Your Benefits on page 6 for more information.

If You're a New Retiree

If you're a new retiree of the County as of January 1, 2005, ***you have 30 days from the date on your enrollment package to enroll*** in your benefits through the Benefits Center and continue your health plan with the County. If you don't enroll within this period, you'll receive automatic benefits coverage under the retiree health plan equivalent to your employee health plan with the exception of the monthly premium. You'll have the opportunity to report errors in your elections within 10 business days from the date on your Benefits Confirmation Statement.

Your retiree health insurance coverage becomes effective on the first day of the month following your termination from County employment due to retirement. Since there will be no lapse in your health coverage, the PPO health plan pre-existing condition exclusions will be waived even if you change health plans and/or add dependents during this one-time retiree enrollment period. If you wish to disenroll from your retiree health coverage, please see page 6.

Premium Payment for New Retirees

As a New Retiree, you will automatically be placed on direct billing, if applicable, to pay for health premiums. After receiving your invoices from Benefit Billing Services, please contact them directly at 1-877-588-0946 for any questions or concerns you may have about your invoice. After receiving your first OCERS pension check, you may contact the Benefits Center to request having your health premiums come out of your pension check and to stop any further direct billing. If for any reason, at any time, your pension check is unable to cover to full health premium amount, you will be reverted back to direct billing. The only time you will be provided with the option of paying for health premiums for your pension check will be at open enrollment.

Retiree Orientation Sessions

Don't forget to attend a retiree orientation session to obtain more information about the Retiree Medical Insurance Program. You received information about the retiree orientations from the Retirement office. You can find information about the Retiree orientations by logging onto the Employee Benefits web site at ***www.oc.ca.gov/hr/employeebenefits***.

If You Change Your Home Address

If you change your home address, you must call the Benefits Resource Line and speak to a Benefits Specialist. It's important that the Benefits Center has your correct home address in order to send you important information about your Retiree Medical Insurance Program. You should also notify any other organization with which you are affiliated in regards to your benefits.

If You Move Out of Area

If you're enrolled in an HMO plan and move outside of your plan's network, you must enroll in another HMO if available in your area or in one of the PPO plans. If you do not enroll, you'll be automatically defaulted to the Premier Wellwise PPO plan. For more information about how the PPO plans work, see page 20.

When You Turn 65

Three months before you or a covered spouse turns 65, you'll receive a "Turning Age 65" package from the Benefits Center, which provides information on your health plan options. You must enroll in Medicare in order to receive or continue to receive your Retiree Medical Grant, the discounted health plan premiums, and maximum health plan benefits, and/or to enroll in Kaiser Senior Advantage. See page 15 for more information about enrolling in Medicare.

Important Notes About Disenrolling from Retiree Health and/or Medicare Coverage

You have the option to disenroll from County retiree health coverage, Medicare coverage, or both. If you disenroll from retiree health coverage and are:

- Under age 65 – If you disenroll from a County retiree health plan before you enroll in Medicare, you and your dependents will be permanently disenrolling from the County Retiree Medical Insurance Program, which includes the County retiree health plan coverage and the Retiree Medical Grant (see page 14 for details on the Retiree Medical Grant). This means you'll be prohibited from enrolling in a County retiree health plan and receiving the Retiree Medical Grant in the future.
- Over age 65 – If you disenroll from a County retiree health plan but are enrolled in Medicare, you'll be permanently disenrolling from the County retiree health plan. This means you'll be prohibited from enrolling in a County retiree health plan in the future. You'll continue to be eligible for the Retiree Medical Grant but the grant can only be used toward Medicare premium reimbursement. For more information on the Retiree Medical Grant, see page 14.

An exception to these rules applies to a retiree who is married to either another County retiree (RMR) or to a County employee (RME). If this is your situation, please see page 12.

The Last Step on Your Pathways to Benefits

After you enroll, you'll receive a Benefits Confirmation Statement in the mail. You can also print a statement if you enroll online. Be sure to review the statement to make sure it correctly reflects your benefit elections. If any of the information on your statement is incomplete or incorrect, call the Benefits Resource Line right away and speak with a Benefits Specialist. You'll have 10 business days from the date of your Benefits Confirmation Statement to report errors in your elections. For Open Enrollment, if you don't receive a Benefits Confirmation Statement shortly after making your elections, please call the Benefits Resource Line right away to notify a Benefits Specialist.

Making Changes to Your Benefits

You may change your benefits between Open Enrollment periods if you experience certain life events. The list below defines some of the acceptable situations where a change is permitted:

- You marry, divorce, become legally separated or your marriage is annulled
- You gain a dependent through birth, adoption or placement for adoption
- Your dependent dies
- Your dependent no longer meets the eligibility requirements
- You or your spouse has a change in employment status that results in gaining or losing eligibility for coverage
- You or your dependent moves to a location where your current coverage is not available

Any change that you make in your coverage must be made within 30 days of the life event and must be consistent with that event. If your life event allows you to add or drop dependents, simply log onto the Benefits Center Web Site at ***www2.benefitsweb.com/countyoforange.html*** or call the Benefits Resource Line at 1-866-325-2345 and speak to a Benefits Specialist. Keep in mind that HMO contracts do not allow you to add newly eligible dependents after the 30-day period. Dependents added to a PPO plan outside of Open Enrollment are subject to the plan's pre-existing condition exclusion provision.

Pathways to Enrollment: Enrolling Step-by-Step

You Can Click or Call to Enroll

As you now know, Open Enrollment for 2005 is a paperless process. This means that, beginning November 1, 2004, you can enroll through the County of Orange Benefits Center in one of two ways:

- Click on the Web — You can enroll online at the Benefits Center Web Site at ***www2.benefitsweb.com/countyoforange.html*** any time during Open Enrollment.
- Call on the phone — You can call the toll-free Benefits Resource Line at 1-866-325-2345 and speak to a Benefits Specialist to enroll. Benefits Specialists are available Monday through Friday, from 7:30 a.m. to 5:30 p.m., Pacific Standard Time, except for holidays.

November Open Enrollment

This year, Open Enrollment will take place November 1 through 26, 2004. This will be your only opportunity to make changes to your benefits for 2005, unless you have a life event.

Remember, you can enroll online or enroll on the phone by speaking to a Benefits Specialist until 5:30 p.m. on November 26, 2004. Enroll early to avoid running out of time!

Making Changes to Your Benefits Outside Open Enrollment

Generally, Open Enrollment is the only time during the year that you can make changes to your benefits unless you have a life event. Some life events include marriage, divorce, adoption, birth, and death. For more information about life events, see Making Changes to Your Benefits on page 6.

If you're a new retiree, you have 30 days from the date on your enrollment package to enroll in your benefits for the first time. After this 30-day period, you won't be allowed to change your benefit elections until the next Open Enrollment period, unless you have a life event such as a marriage, divorce, birth, or death.

Transition Period Between November 1, 2004 and December 31, 2004

If you have a qualified life event between November 1, 2004 and December 31, 2004 and want to make changes to your benefits, you must call the Benefits Resource Line within 30 days of your qualified life event. You may need to confirm or make elections to ensure your qualified event is covered under the current and upcoming plan year. If you have any questions please contact the Benefits Resource Line and speak with a Benefits Specialist.

Who Should Enroll?

If you don't want to make changes to your benefits or dependent coverage as shown on your Benefits Enrollment Summary, you do not need to enroll during Open Enrollment.

However, you ***must enroll*** if you want to:

- Add or drop dependents from your coverage
- Change your retiree health plan

The coverage shown on your Benefits Enrollment Summary *is* how you will be enrolled if you do not make any changes within the stated deadline. Review it carefully and within the required timeframes, including the dependent coverage section, as no changes can be made after the deadline.

Once you receive your Confirmation Statement you must report any errors within 10 business days from the date on the statement.

When to Click or Call

The Benefits Center makes it easy to enroll and get information about your benefits. You can enroll online or by calling the Benefits Resource Line and speaking to a Benefits Specialist. You can also find information about your benefits on the Benefits Center Web Site or on the Benefits Resource Line without speaking to a Benefits Specialist. If you can't find the information you need on the automated system, you may speak to a Benefits Specialist.

Here's a summary of the types of information available and the kinds of changes you can make — online or by phone.

	Log on to the Benefits Center Web Site to…	Call the toll-free Benefits Resource Line to…	Speak Live to a Benefits Specialist to…
Review your automatic benefits coverage for 2005	✔	✔	✔
Find out the cost of your benefit elections	✔		✔
Confirm who is covered under your benefit plans	✔	✔	✔
Enroll for coverage at Open Enrollment	✔		✔
Use tools such as Health Plan Comparison Tool to help you make decisions about your benefits	✔		
View and print health plan Provider Directories	✔		
Record any life event change	✔		✔
Change dependent information	✔		✔
Request forms you may need	✔	✔	✔
Find answers to your questions about benefits	✔		✔

What to Have with You When You Enroll

When you enroll either online or on the phone, you should have the following items handy:

- Your Social Security Number
- Your Benefits Enrollment Summary
- Your Personal Identification Number (PIN) (listed in the first sentence of the Summary)

If you're electing the CIGNA Private Practice Plan HMO, you must select a Primary Care Physician (PCP) for each covered person and enter that PCP's identification (ID) number when you enroll. You can find a list of PCP ID numbers by clicking on the "Quick Links" link on the "Selection Menu" screen and following the links to provider sites or by going directly to the CIGNA web site at ***www.mycigna.com/general/misc/docdir.html.***

Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary is a valuable tool to help you make your choices at Open Enrollment. You'll find your Benefits Enrollment Summary in your enrollment package. This summary shows:

- Your PIN
- Your 2005 automatic benefits coverage
- The benefits you're eligible to enroll in for 2005
- Your cost for each benefit

The coverage shown on your Benefits Enrollment Summary *is* how you will be enrolled if you do not make any changes within the stated deadline. Review it carefully and within the required timeframes, including the dependent coverage section, as no changes can be made after the deadline. Once you receive your Confirmation Statement you must report any errors within 10 business days from the date on the statement.

Keep this summary with you as you enroll, since it includes important information about your benefits, as well as your PIN. Without your PIN, you won't be able to access the Benefits Center Web Site. Keep in mind that you can also access your Benefits Enrollment Summary on the Benefits Center Web Site. If you don't know your PIN, call the Benefits Resource Line, press **0, and speak with a Benefits Specialist.

How You Can Change Your PIN

When you log on to the Benefits Center Web Site or call the Benefits Resource Line for the first time, you'll be prompted to change your PIN. You can also change your PIN any time you want. You have two ways to change your PIN:

- Online — Simply log on to the Benefits Center Web Site and click on the "PIN Change" link. Then, just follow the on-screen instructions to change your PIN.
- On the phone — Call the Benefits Resource Line and follow the instructions to change your PIN, where you'll be prompted to enter a new PIN.

How to Read Your Benefits Enrollment Summary

Your personalized Benefits Enrollment Summary lists your name and address in the upper left corner and your PIN in the first sentence of the Summary. Below that, the first section of the summary shows all of the automatic benefits you're eligible to receive. Automatic benefits are those benefits you'll receive if you don't make any changes at Open Enrollment. Moving from left to right, the information on the summary includes:

- The name of the benefit
- Your automatic benefits coverage for 2005
- Your coverage level
- Your cost, both before-tax and after-tax, if applicable

In the next section, you'll find all the benefits for which you're eligible. Moving from left to right, the information on the summary includes:

- The benefit name and option number
- Your cost by type of coverage level

You should use this Benefits Enrollment Summary to plan for enrollment. Carefully review the benefits for which you're eligible before you enroll — to decide which benefits you'd like to elect for 2005. You can even highlight the benefits you plan to enroll in on your summary so that you can quickly and easily reference them as you enroll.

How to Enroll on the Benefits Center Web Site

At the Benefits Center Web Site, you have information right at your fingertips. You can access the site from any computer with Internet access, at home or at work. Here are the first steps you need to take to get started down the pathways to your benefits online:

1. Simply type the Web Site address, **www2.benefitsweb.com/countyoforange.html**, into your browser and press "Enter."
2. You'll be prompted to enter your social Security Number and Personal Identification Number (PIN) to access the "Selection Menu." Your PIN is listed on the personalized Benefits Enrollment Summary enclosed in your package.
3. The first time you log on to the Web Site, you'll automatically be prompted to change your PIN. Just follow the instructions on the web screen to change your PIN.
4. You'll then be sent to the "Selection Menu" screen. From the "Selection Menu" screen, just click on the option from the list provided: "Health and Welfare" or "Message Center." This will advance you to the next level.
5. If you selected the option "Health and Welfare," just click on the appropriate link in the left navigation bar on your screen depending on what you'd like to do.

Steps to Enroll Online:

From the "Selection Menu" screen, click on the "Open Enrollment" link in the navigation bar on the left side of the screen. You'll see five options:

From **November 1 through November 26, 2004**, you have the opportunity to make your 2005 benefit elections. The following is a brief description of the Open Enrollment sections of this Web Site.

- ***Learn More About This Event:*** Links to an overview of the benefits available to you in 2005.
- ***Compare Health Plans:*** Provides a way for you to compare health plans and plan features that are important to you. If you want to view a printable version of the *Health Plan Comparison Chart,* click on *Request/Print Materials* in the navigation bar on the left side of the screen and select *Health Plan Comparison Chart.*
- ***Link to Health Plans and Summaries:*** Provides links to PPO Plan documents and HMO Group Service Agreements that provide detailed information about your County of Orange benefit plans.
- ***Enroll/Change Elections:*** Enables you to make changes to your benefit elections and/or dependent information for the plan year beginning January 1, 2005. You will see the Enrollment Summary page, which provides a summary of your coverage and/or dependent information for January 1, 2005 through December 31, 2005. Click on the coverage(s) and/or dependent information in this section to make your Open Enrollment changes.
- ***Review Your Elections:*** Allows you to see all the benefits you are eligible for through the County of Orange. If you click on *Review Your Elections* and have not made any changes, the benefit coverage you will see are the benefits you will receive in 2005. If you have saved changes, this screen will show your new elections.

To review your current benefit elections, click on *Coverage Overview* on the left navigation bar.

To begin, choose from the available functions listed under this event on the left navigation bar.

If you choose to change your 2005 benefit elections, you'll be able to change only those benefits for which you're eligible. Follow the instructions on the screen to change your benefits or add or drop dependents.

Once you've made your elections, you'll be prompted to save your changes by clicking "Save All Changes" at the bottom of your screen. You'll also have the option to cancel changes. If you're satisfied with the changes you've made, click "Save All Changes."

Once you save your changes, the site will generate your Benefits Confirmation Statement on screen, which lists your benefit elections for 2005. You can print a copy of this statement for your records if you like. You'll also receive a Benefits Confirmation Statement in the mail after you enroll. For more information on this statement, see Your Benefits Confirmation Statement on page 11.

Online Tools to Help You:

In addition to your Benefits Enrollment Summary, the Benefits Center Web Site offers tools to help you make the best choices for you and your family. From the Open Enrollment screen, you can access:

- Compare Health Plans — During Open Enrollment or after you have reported a life event, you can select multiple County health plans and make a side-by-side comparison of the benefits and levels of coverage they offer. Just click on the health plans you want to compare and select the benefit features that you want to compare. This information will automatically appear on your screen in a side-by-side comparison chart.
- Model a Life Event — This tool can help you plan for the future. You'll be able to type in different scenarios and find out how each scenario would affect you financially. For example, you can determine how much your health plan cost will be if you add a dependent to your health plan.

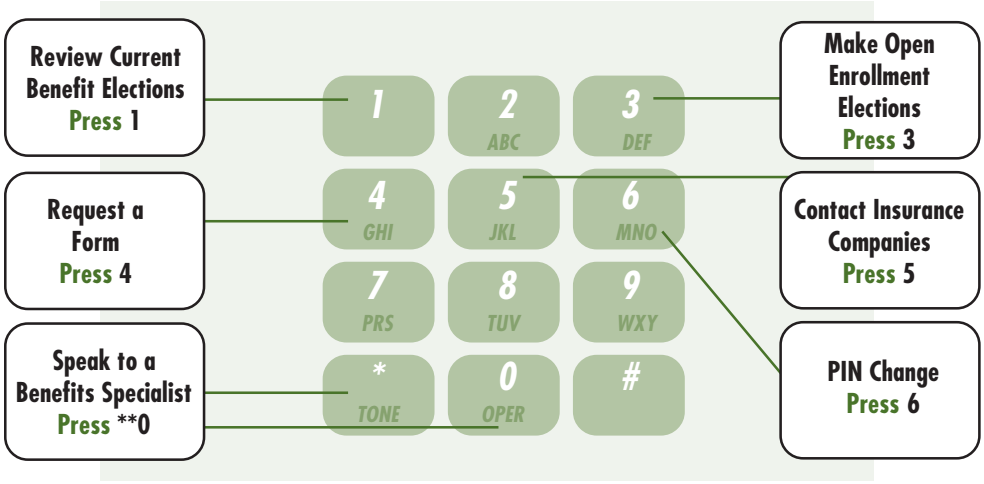
How to Enroll on the Benefits Resource Line

When you call the Benefits Resource Line, you can:

- Enroll or ask questions by speaking to a Benefits Specialist
- Review your elections, change your PIN, and request forms through the automated system

Here are the steps to get you started:

1. Dial the toll-free Benefits Resource Line phone number, 1-866-325-2345.
2. You'll be prompted to enter your Social Security Number and PIN to get to the Benefits Selection Menu. If this is your first time calling the Benefits Resource Line, you'll be prompted to change your PIN.
3. From the Benefits Selection Menu, you'll hear a list of options. Just select the option that you want and press the corresponding number on your phone's keypad.



From the Benefits Selection Menu, you can select:

**0 Speak to a Benefits Specialist — To report a Life Event or enroll or ask questions by speaking with a Benefits Specialist live by pressing **0.

1 Review Benefit Elections — Check out details of the plans available to you by pressing 1.

3 Make Open Enrollment Elections—Transfer you to a Benefits Specialist by pressing 3.

4 Request a Form —You can request forms you need for certain County programs by pressing 4.

5 Contact Insurance Companies — Access important insurance company contact information by pressing 5.

6 PIN Change — You can change your PIN any time you like by pressing 6.

Exit the System — To exit the system, follow the instructions to end your session.

Steps to Enroll by Phone:

To enroll or change dependents, you need to talk to a Benefits Specialist. Simply select the "Speak to a Benefits Specialist" option and he or she will enroll you in your benefits.

Your Benefits Confirmation Statement

After you enroll, you'll receive a Benefits Confirmation Statement in the mail. Review this statement carefully to make sure all of your benefits are correct. If you find an error or if you don't receive a statement, call the Benefits Resource Line right away and speak to a Benefits Specialist. You'll have 10 business days from the date of your statement to report errors in your elections.

How the Pathways to Benefits Program Works

The County provides a Retiree Medical Insurance Program to help you take care of and protect yourself and your family. If you're eligible, the County's retiree health benefits include retiree health plan coverage and a Retiree Medical Grant to help you pay for your health plan coverage and/or Medicare premiums.

Your age and Medicare eligibility affect the benefits for which you're eligible. Be sure to read this guide carefully so you'll have the information you need to make the right choices for your personal situation.

Who is Eligible?

Retiree Health Care Coverage

As a retiree of the County, you're eligible for retiree health care coverage if you:

- Were enrolled in a County health plan at the time you retired
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (OCERS)

Your eligible dependents for retiree health coverage include your:

- Legal spouse
- Domestic partner (see page 28 for more details)
- Unmarried children under age 19 or under age 23 if full-time student, including stepchildren, foster children, children placed for adoption, and legally adopted children. Dependent children who are full-time students must attend an accredited school, college or university (12 units or more) and must be dependent on you for financial support to continue to be covered
- Unmarried incapacitated children of any age if they depend on you for financial support, enrolled in your health plan and are incapacitated prior to age 19

Proof of adoption or legal guardianship may be requested at any time. Dependents over age 19 may be required to provide proof of full time student status to the County's carriers and administrators at any time.

Retirees must notify the Benefits Center within 30 days of a dependent no longer meeting eligibility requirements. The retiree must go onto the Benefits Center Web Site or contact the Benefits Resource Line to disenroll their ineligible dependent.

Retiree Married to an Employee (RME)

If you're a retiree married to a County employee (RME) and you're eligible to be enrolled as a dependent on your spouse's County health plan, you may elect either to be enrolled individually in a retiree health plan with your Retiree Medical Grant or be enrolled as a dependent under your spouse's employee health plan.

If you elect coverage as a dependent on your spouse's health plan, your Retiree Medical Grant will be suspended while enrolled under your spouse's employee health plan. If you later decide to change your enrollment status and enroll in the retiree health plan, you may do so during annual Open Enrollment. If you have a life event (e.g., divorce) midyear that necessitates that you enroll in the retiree health plan, you must enroll in the retiree health plan within 30 days of the life event. Your retiree health coverage and Retiree Medical Grant will then become effective on the first of the month following the life event.

If you're an RME, you must self identify by calling the Benefits Resource Line to speak with a Benefits Specialist for additional information on how to enroll under the County health plans.

Retiree Married to a Retiree (RMR)

If you're a County retiree married to another County retiree (RMR) and you enroll in the same County retiree health plan, one of you must be enrolled as a subscriber and the other must be enrolled as a dependent. You may combine your Retiree Medical Grants when you enroll as an RMR in the same health plan. You may also choose to enroll in different health plans and use your Retiree Medical Grants separately.

If you're an RMR, you must self identify by calling the Benefits Resource Line for additional information on how to enroll under the County retiree health plans.

RME and RMR Participants Must Enroll on the Benefits Resource Line

If you're a Retiree Married to an Employee or a Retiree Married to a Retiree (RME or RMR) from the County, you won't be able to enroll in your health plan online. You must call the Benefits Resource Line and speak to a Benefits Specialist to enroll.

If you're participating in the RME or RMR program for the first time, you'll also need to fill out the RME or RMR Enrollment form, available on the Benefits Center Web Site. Just click on the "Request/Print Materials" link from the "Selection Menu" screen. If you're a current retiree, you'll need to return your form to the Benefits Center by the Open Enrollment deadline. If you're a new retiree, you'll need to return your form to the Benefits Center within your 30-day enrollment period.

Retiree Medical Grant

When you retire, you may receive a Retiree Medical Grant from the County to use towards the cost of your County health plan and/or Medicare plan premiums. To be eligible to receive your Medical Grant, you must:

- Have a minimum of 10 years of continuous County service hours, if you have a normal retirement (However, if you've been granted a service connected disability, there is no minimum service requirement. If you've been granted a non-service connected disability, you must have a minimum of five years of service.)
- Be at least 50 years old at your date of separation
- Receive a monthly retirement allowance from the Orange County Employees Retirement System
- Be enrolled in a County health plan at the time of retirement

The amount of the Retiree Medical Grant you receive is based on your years of eligible County service hours to a maximum of 25 years of service. The increase of the Medical Grant is determined by the average increase of all the County's health plans to a maximum of 5% each calendar year.

For details on how the Retiree Medical Grant pays for coverage see page 14.

Survivor Benefits

If you're a survivor of a deceased County employee or retiree, you may be eligible for coverage under the County retiree health plan and eligible for a Survivor Retiree Medical Grant.

Survivor Health Care Coverage

To be eligible for survivor health care coverage, you must:

- Be covered under the employee's/retiree's health plan at the time of his/her death
- Receive a monthly retirement allowance from the Orange County Employees Retirement System (exceptions to this rule include dependent children who are under age 19, or under age 23 if full-time students, who aged out of receiving a monthly retirement allowance from OCERS but are still eligible under the plans, incapacitated children and surviving spouses who aren't eligible for receiving a monthly retirement allowance but are eligible for health care coverage.)

The only dependents that can be covered are those who had coverage on the employee's/retiree's plan at the time of death.

Survivor Retiree Medical Grant Benefits

If you're a survivor of a Retiree Medical Grant eligible County employee/retiree who is deceased, you may be eligible for a survivor Medical Grant. To be eligible, you must:

- Receive a monthly retirement allowance from the Orange County Employees Retirement System and
- Be covered under the County employee's/retiree's health plan at the time of his/her death

If you're eligible, you'll receive 50% of the Retiree Medical Grant that would have been available to the employee/retiree to use towards the cost of County retiree health plan and/or Medicare coverage.

Retiree Health Costs

Information regarding the cost of the various retiree health plan options is available online through the Benefits Center Web Site and on your personalized Benefits Enrollment Summary. Health care costs are increasing significantly in 2005. Be sure to review the various plan options to select the plan that best fits your and your family's needs.

Retiree Medical Grant Helps Pay for Coverage

When you retire, you may be eligible for a Retiree Medical Grant to use towards the cost of your County health plan and/or Medicare premiums.

The Retiree Medical Grant will be applied first to offset the cost of your and/or your spouse's health plan premium. Any remaining monthly Medical Grant will be applied to your Medicare premium reimbursement, if applicable. You cannot receive the Medicare reimbursement if you're currently receiving Medicare reimbursement from another source.

If the total of your monthly health plan premium, plus your monthly Medicare premium reimbursement is less than the total monthly Retiree Medical Grant, the excess Medical Grant will remain in the Retiree Medical Insurance Program.

Please note: If you're a new retiree, you'll be direct billed for your premium. You must contact the Benefits Center if you'd like your retiree health plan premium deducted from and reflected on your OCERS pension check.

If you have questions about your retiree health plan premium or your Retiree Medical Grant amount, please call the Benefits Resource Line and speak to a Benefits Specialist. If you have questions regarding any other deductions or about your monthly retirement allowance, please call the Orange County Employees Retirement System at 714-558-6200.

Retiree Medical Grant Examples

Example 1:

If John retires from the County after 20 years of service, his Retiree Medical Grant would be $313.40 for 2005. Both he and his spouse are enrolled in the Premier Wellwise Plan and Medicare Parts A and B. The following would appear on his pension check:

John's monthly premium is listed as a current deduction of:	$872.86
John's monthly Retiree Medical Grant (listed as MED GRT) - which applies towards the cost of his premium is:	$313.40
The net monthly amount John pays is:	$559.46

In this case, John has no remaining Retiree Medical Grant credit to apply toward his Medicare premium.

Example 2: If Elena retires from the County after 23 years of service, her monthly Retiree Medical Grant would be $360.41. She is enrolled in Kaiser Senior Advantage, Medicare Parts A and B, and has no dependents. The following would appear on her pension check:

Elena's monthly premium is listed as a current deduction of:	$185.73
Elena's monthly Retiree Medical Grant (listed as MED GRT) which applies towards the cost of her premium is:	- $185.73
Elena has $174.68 left over that can be used to pay for her Medicare B premium ($360.41 -$185.73 = $174.68):	- $174.68
The net monthly amount Elena pays is:	$ 0.00

In this case, Elena's Retiree Medical Grant pays for her premium of $185.73 and provides a $174.68 credit to reimburse her for the cost of her Medicare Part B premium. The excess grant amount remains in the Retiree Medical Insurance Program.

Important Medicare Information

This section provides important information about Medicare and how it affects the cost of your retiree health care coverage and your Retiree Medical Grant. Be sure to review it carefully.

If you have any questions, please access the Benefits Center Web Site at ***www2.benefitsweb.com/countyoforange.html*** or call the Benefits Resource Line toll-free at 1-866-325-2345 and follow the instructions to speak with a Benefits Specialist.

Enrolling in Medicare

All eligible retirees and their dependents who are age 65 or older must be enrolled in Medicare Part B to be eligible to receive the Retiree Medical Grant. You may be asked to submit documentation of your Medicare enrollment. Failure to submit proof of Medicare coverage (e.g., copy of Medicare card) will result in suspension of your Medical Grant and automatic enrollment in an applicable health plan.

If You're a Current Retiree

If you or your spouse turn age 65 after you retire, you have 90 days from your 65th birthday to enroll in Medicare Parts A (if eligible) and/or B.

If You're a New Retiree

As a new retiree, you and your spouse, if age 65 or older, are required to enroll in Medicare to receive the monthly Retiree Medical Grant. You have 90 days from the date of your retirement to enroll in Medicare through Social Security.

Medicare has two parts:

- Medicare Part A — For those who qualify (if you have 40 credits under Social Security or about 10 years of work or you can qualify if your spouse is eligible for Medicare) provides basic benefits for inpatient stays in hospitals and skilled nursing facilities. Part A is provided as part of your Social Security benefits.
- Medicare Part B — Supplements Part A coverage for certain outpatient medical needs such as physician services, physical therapy, diagnostic X-rays and laboratory and other tests. You are responsible to pay a monthly premium for Part B coverage.

To enroll in Medicare, simply call the Social Security Administration at 1-800-772-1213 and ask for information about enrolling in Medicare.

Make Your Life Easier: Get a Head Start on Medicare Enrollment

Be sure to contact the Social Security Administration 90 days before your or your spouse's 65th birthday (or retirement date if retiring after age 65) to begin the process of enrolling in Medicare.

Medicare Enrollment Reduces Your Health Premiums

Once you've enrolled in Medicare, your health care premiums will be significantly reduced. The amount of reduction varies depending on the County health plan in which you're enrolled.

If your Retiree Medical Grant is greater than your County health plan premium, you can use the excess grant to reimburse the premium that Medicare charges you and/or your spouse (provided you aren't receiving reimbursement from another source). See Example 2 in the Retiree Medical Grant Examples sidebar on page 15.

Medicare Enrollment Is Required to Receive the Retiree Medical Grant

It is very important to remember that if you and/or your spouse are age 65 or older, you must be enrolled in Medicare Parts A (if eligible) and/or B to be eligible to receive the Retiree Medical Grant. You may be asked to submit documentation of your Medicare enrollment. Failure to submit proof of Medicare coverage (e.g., copy of Medicare card) will result in suspension of your Retiree Medical Grant and automatic enrollment in an applicable health plan with associated costs.

Medicare and the Kaiser Health Plans

The Kaiser HMO is only available to retirees and their spouses under age 65 (ineligible for Medicare). If you enroll in the Kaiser HMO and you and/or your spouse/dependent become eligible for Medicare Parts A and B, or for Medicare B only, the Kaiser HMO will no longer be available to the enrollee who has become Medicare eligible. The Medicare eligible enrollee will be offered the Kaiser Senior Advantage HMO as a replacement.

Kaiser Senior Advantage requires that you assign your Medicare benefits over to the Kaiser health plan. This means you cannot use Medicare to reimburse you for medical services that are obtained outside of Kaiser Senior Advantage facilities and providers. In exchange, your premium for this plan is lower than the other HMOs. Other County plans do not require assignment of your benefits to them, but do require that you be enrolled in Medicare, if eligible. These other County plans will coordinate your benefits with Medicare. For more information on the Kaiser Senior Advantage HMO, see page 19.

Retiree Health Plan Options

The County offers retiree health care coverage through either a:

- Health Maintenance Organization (HMO) plan or
- Preferred Provider Organization (PPO) plan

The chart below shows the plans in which you can enroll depending on your Medicare eligibility and where you live.

Health plans for Retirees and Dependents	With Medicare A&B	Without Medicare A&B	If you live outside of California OR If you live in California but outside of the HMO Service Areas (With or without Medicare)
HMO Plans			
CIGNA Private Practice	✔	✔	
Kaiser		✔	
Kaiser Senior Advantage	✔		
PPO Plans			
Premier Wellwise	✔	✔	✔
Premier Sharewell	✔	✔	✔

How the HMO Plans Work

HMO plans provide a comprehensive array of services, including preventive care, at a minimal cost but you must use only providers in the HMO plan network. A network includes doctors, hospitals, and other health care providers and facilities that have contracted with the HMO to provide care at lower fixed rates and/or discounted rates. HMOs do not generally pay benefits for care received outside the HMO network, except in life/limb threatening emergency situations.

Some important features of HMO plans include:

- Minimal copayments for certain services (e.g., a doctor's office visit)
- No claim forms
- Covered preventive services such as annual physicals, well-baby and well-woman care and immunizations
- No lifetime maximums
- No pre-existing condition exclusions

Your HMO Options

At the County, you have one of three HMO plans to choose from:

- The CIGNA Private Practice Plan HMO (CIGNA HealthCare of Southern California and San Diego)
- Kaiser HMO
- Kaiser Senior Advantage (requires enrollment in Medicare A & B or B only)

CIGNA Private Practice Plan HMO

Here's an overview of how the CIGNA Private Practice Plan HMO works:

- You select a Primary Care Physician (PCP) from the CIGNA network to provide and/or coordinate all your care, including diagnostic tests, referrals to specialists and hospitalizations. Most HMOs require that you select a Primary Care Physician (PCP). With the exception of emergency treatment and self-referrals to OB/GYNs within the same medical group for well woman exams, your PCP must authorize, provide, and/or arrange any special care you may need, such as surgery or referral to a specialist, in order for you to receive benefits.
- When you need care, you contact your PCP's office. At your appointment, present your ID card and pay a small copayment.
- You have easy access to specialists, often with same-day referrals, through the CIGNA Access Advantage Program.
- Female members may schedule their annual well-woman exams while covered under the plan without obtaining a PCP referral.
- When medication is prescribed, you must fill the prescription at a CIGNA contracted retail pharmacy. You pay a small copayment per prescription for up to a 30-day supply. For a list of CIGNA pharmacies, log on to the CIGNA web site or call CIGNA Member Services.
- For maintenance type prescription drugs, you may also order up to a 90-day supply of your medication through CIGNA's mail order program. You can call CIGNA's toll free number, 1-800-TEL-DRUG or 1-800-835-3784, or place your order online through CIGNA's web site, ***www.teldrug.com***
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call your PCP or CIGNA Member Services within 48 hours to receive benefits.
- If you need vision care, call Vision Service Plan (VSP) at 1-800-877-7195.
- CIGNA covers chiropractic care. See page 19 for details.

How to Locate a CIGNA PCP

Directories with a list of PCPs are available by visiting the Benefits Center Web Site at ***www2.benefitsweb.com/countyoforange.html***, clicking on "Quick Links" in the navigation bar, and selecting the CIGNA Private Practice Plan web address. You can also log onto the CIGNA web site at www.mycigna.com/general/misc/docdir.html or call CIGNA member Services at 1-800-244-6224. If you're electing the CIGNA Private Practice Plan HMO for the first time or adding a dependent, you'll need to enter this PCP information when you enroll.

Kaiser HMO

- Health services must be provided by Kaiser physicians and hospitals. You do not need to select a Primary Care Physician (PCP) to coordinate your care. Provider directories are available on the Employee Benefits web site at ***www.oc.ca.gov/hr/employeebenefits*** or Kaiser's web site at ***www.kaiserpermanente.org.***
- When you need care, you contact the Kaiser appointment center in your area. At your appointment, present your ID card and pay a small copayment.
- You can also go directly to Kaiser specialists who provide OB/GYN, optometry, or mental health services.
- You have access to "KP Online" at **www.kponline.org** – a web site that offers health information and allows you to schedule appointments on the Internet. You can also get this information via Kaiser's toll-free phone number.
- When medication is prescribed, you must fill the prescription at a Kaiser pharmacy. You pay a small copayment per prescription for up to a 100-day supply. Dental prescriptions are included in your coverage.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call Kaiser within 24 hours to receive benefits.
- Kaiser covers chiropractic care. See page 19 for details.

Chiropractic Care

Under the CIGNA and Kaiser HMOs, you have direct access to a network of more than 2,400 chiropractors throughout California through American Specialty Health Plans (ASHP). You simply contact an ASHP chiropractor, make an appointment, and pay your copayment at each visit. For a directory of participating chiropractors, visit the Benefits Center Web Site and click on "Quick Links" on the navigation bar and go to American Specialty Health Plans or visit the ASHP web site at **www.americanspecialtyhp.com** or call ASHP Customer Service at 1-800-678-9133, Monday through Friday, 5 a.m. to 8 p.m., or Saturday from 6 a.m. to 3 p.m. Pacific Standard Time.

Kaiser Senior Advantage HMO (Available to Retirees Enrolled in Medicare Parts A & B)

Under the Kaiser Senior Advantage HMO, you must use the plan's contracted providers at all times, except for emergencies or urgent care services. When you enroll in a Medicare assignment plan, like the Kaiser Senior Advantage HMO, benefits are paid only for health care received through the Kaiser Senior Advantage HMO network. This means that you can't use Medicare to reimburse yourself for medical services you obtain from providers outside of Kaiser Senior Advantage facilities and providers.

To elect the Kaiser Senior Advantage HMO, you and your dependents must be enrolled in Medicare Parts A and B and live in Kaiser's California service area.

This plan is designed especially for seniors and features:

- Hospital and physician services
- Prescription drug coverage with no annual limit
- No claim forms to fill out
- Enhanced benefits such as dental care, hearing exams, podiatry, and hospice care
- Preventive care and wellness programs

Here's an overview of how the Kaiser Senior Advantage HMO works:

- You must be enrolled in Medicare Parts A and B to participate in this plan. You also must assign your Medicare benefits to Kaiser.
- Health services must be provided by Kaiser physicians and hospitals. You do not need to select a Primary Care Physician (PCP) to coordinate your care. Provider directories are available on the Employee Benefits web site at ***www.oc.ca.gov/hr/employeebenefits***.
- When you need care, you contact the Kaiser appointment center in your area. At your appointment, present your ID card and pay a small copayment.
- You can also go directly to Kaiser specialists who provide OB/GYN, optometry, or mental health services.
- You have access to "KP Online" at ***www.kponline.org*** – a web site that offers health information and allows you to schedule appointments on the Internet. You can also get this information via Kaiser's toll-free phone number.
- When medication is prescribed, you must fill the prescription at a Kaiser pharmacy. You pay a small copayment per prescription for up to a 100-day supply. Dental prescriptions are included in your coverage.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call Kaiser within 24 hours to receive benefits.
- Kaiser covers chiropractic care. See above for details.

For more details on the HMO plan options, see the Health Plans At-A-Glance comparison chart on pages 23-25.

How the PPO Plans Work

Preferred Provider Organizations (PPOs) give you the freedom to choose any doctor, whether or not he or she is a member of the PPO network, every time you need care. You do not need to select a PCP to coordinate your care and you can see a specialist any time you wish.

Important: There is a pre-existing condition clause for all the PPO health plans if you enroll in any of the PPO plans outside the Open Enrollment period. See the specific PPO Plan Document located on the Benefits Web Site at "Request/Print Materials" on the navigation bar.

When You See an In-Network Provider, You…	When You See an Out-of-Network Provider, You…
Pay an annual deductible before the plan pays benefits	Pay an annual deductible before the plan pays benefits
Receive a higher level of benefits	Receive a lower level of benefits
Pay a percentage of a discounted rate for services	Must pay a percentage of the usual, reasonable and customary (URC)* charges plus any amounts above URC charges
Have less paperwork (Provider processes the paperwork and submits claims)	Pay up front, file a claim form, and wait for reimbursement in some instances

*Usual, Reasonable and Customary (URC) charges are the usual charges to provide a health service in your geographic area as determined by the plan. When providers join the PPO network, they agree to charge lower fees that are less than URC limits.

Your PPO Options

You have two PPOs to choose from:

- Premier Wellwise PPO
- Premier Sharewell PPO

Here's an overview of how these plans work:

- Each time you need care, you can choose an in-network (PPO) or out-of-network (non-PPO) health care provider. PacifiCare Signature Options℠ (PPO) is the preferred provider network. Provider directories are available on the Benefits Center Web Site, go to "Quick Links" and click on the PacifiCare web address or you can call PacifiCare at 1-800-908-9185 for assistance. Although the PPO plans share the same provider network, they have different deductibles and coinsurance amounts. Please see the Health Plans At-A-Glance comparison chart on pages 23-25 for details.
- When you see a PPO provider, you simply present your ID card at your appointment. Your provider files the paperwork for your claim and you receive a bill in the mail for your deductible and/or coinsurance amount, usually 10% of the cost for most covered services.
- When you see a non-PPO provider, you generally pay 20% of the cost for most covered services and, in some instances, may have to pay up front.
- Both PPO plans pay 100% of eligible health care expenses that are in excess of $10,000 per calendar year per participant.
- If you're scheduled for hospital admission or surgery, you must contact the claims administrator, PacifiCare, to obtain precertification for the hospital stay before admittance in order to receive the higher benefits.
- In an emergency, seek care at the nearest hospital and call or have your doctor or family call PacifiCare within 24 hours to receive the higher level of benefits.

PacifiCare Signature Options℠ (PPO)

Each of the County PPO plans uses the PacifiCare Signature Options℠ (PPO) as its Preferred Provider Organization Network. PacifiCare Signature Options℠ (PPO) includes more than 3,000 hospitals and 600,000 physicians across the country. You can use an online provider directory to find out which hospitals and doctors are in the network by logging onto the Benefits Center Web Site, go to "Quick Links" and click on the PacifiCare web address or you can call PacifiCare at 1-800-908-9185 for assistance.

Prescription Drug Benefits – Premier Wellwise PPO

If you enroll in the Premier Wellwise PPO, Caremark will administer your prescription drug coverage. Caremark offers discount prices on name brand and generic drugs with no annual deductible and no claim forms. Caremark also has a large network of more than 2,940 participating pharmacies in Southern California and 55,000 across the country, including most major pharmacies like Rite-Aid, Savon, and Costco and offers state-of-the-art mail service (mail order) facilities.

You must fill your prescriptions through Caremark's participating retail pharmacies or through their mail service program. Prescriptions obtained as a result of an emergency must be filed with PacifiCare, the claims administrator. When you purchase prescription drugs from a Caremark retail pharmacy, you will always present your health plan ID card to the pharmacist.

For mail service prescription drugs, if you have a new "maintenance" medication prescription, you may simply fill out a Caremark Mail Service Order Form, attach your original prescription, and send it to Caremark. A pre-addressed Caremark Mail Service Order Form will be available in your Caremark Prescription Welcome Booklet. Caremark forms are available on the Benefits Center Web Site and the address is on the form. You should have your physician write two prescriptions: one for up to a 90-day supply plus refills, to be ordered through Caremark's Mail Service Program, the other to be filled immediately at a Caremark participating pharmacy until you receive your prescription from the Mail Service Program. For refills, you can order online through Caremark's web site, by phone or by mail. Be sure to order three weeks in advance of your current prescription running out.

Here's an overview of Caremark prescription drug coverage:

Premier Wellwise Prescription Drug Benefits	
Retail Pharmacy (up to a 30-day supply)	Caremark Pharmacy
Generic drugs	You pay 20%; plan pays 80%
Name brand drugs	You pay 20%; plan pays 80%
Mail-order Pharmacy (up to a 90-day supply)	Caremark Mail-order Pharmacy
Generic drugs	You pay 20%; plan pays 80%
Name brand drugs	You pay 20%; plan pays 80%

You always save money by ordering generic drugs (if available) instead of name brand drugs. Although you pay the same coinsurance of 20% for generic and name brand drugs, you'll pay less money for generic drugs since they cost less. You may also save additional money for maintenance type drugs if you order through Caremark's Mail Service Program and you can order your refills conveniently without going to a pharmacy.

Prescription Drug Benefits – Premier Sharewell PPO

If you enroll in the Premier Sharewell PPO plan, PacifiCare administers your prescription drug coverage. You can fill your prescriptions at any retail pharmacy. You pay the cost of the prescription up front, and then send a claim with attached receipts to PacifiCare and wait for reimbursement. You must satisfy the annual deductible before the plan pays 80% of the cost of covered prescription drugs.

Things to Consider If Selecting a PPO Plan

Although the County's PPO plans work in a very similar manner, there are some differences in benefits, such as different deductibles, coinsurance (the percentage of the cost you pay for services), and prescription drug coverage. Here are a few examples:

- The Premier Wellwise PPO offers wellness incentives – up to a $200, $400, or $500 taxable rebate, depending on the level of coverage you elect, if you or your dependents, if enrolled, don't file any claims or fill prescriptions using your Caremark card during the year, as well as a $50 year-end taxable cash award for non-smokers/subscribers only.
- The Premier Sharewell PPO has a $5,000 annual deductible per family and is designed for retirees who have Medicare coverage or other health insurance coverage but want to supplement their family's coverage.

That's why it's important to review the Health Plans At-A-Glance comparison chart on pages 23-25 for more details if you're thinking about electing a PPO plan.

Health Plan Decision Guidelines

Here are some things to think about as you decide which health plan is right for you:

- Are the family doctors and specialists your family prefers part of the network? If not, are you willing to change doctors?
- If provider location is important to you, check to see if the network facilities are close to your home.
- How much do you and your family typically spend on health care each year? How much are you willing to pay out-of-pocket for health care expenses? Remember that the PPO plan pays a higher percentage of expenses when you use network providers. HMOs require flat copayments for most services, with no deductible, but you must use only HMO providers to have your expenses covered.
- What do you value more – having the lowest possible out-of-pocket costs (HMO options) or the flexibility to see any provider you wish (PPO options)?

Health Plan Identification Cards and Claim Forms

All participants enrolled in a PPO, Cigna, or are new to Kaiser health plan will receive a new identification (ID) card for 2005. All other Kaiser participants may continue to use their existing identification (ID) card. If you need a replacement card or the information on the card you receive is incorrect, contact your health plan's Member Services Department directly.

If you're required to submit a claim to receive plan benefits, claim forms are available directly from the Benefits Center Web Site or by calling the Benefits Resource Line.

If You Have a Life Event Between November 1 and December 31, 2004

If you have a qualified life event between November 1, 2004 and December 31, 2004 and want to make changes to your benefits, you must call the Benefits Resource Line within 30 days of your life event. You may need to confirm or make elections to ensure your qualified event is covered under the current and upcoming plan year. If you have any questions please contact the Benefits Resource Line and speak with a Benefits Specialist.

Health Plans At-A-Glance

Kaiser Senior Advantage Retirees (With Medicare A & B and / or B Only)

Special Plan for Retirees With Medicare A & B or B Only

Kaiser Permanente offers a health plan specifically designed for Retirees who are covered under Medicare Parts A & B or B only and live in the approved Southern California service area.

This health plan is especially designed with enhanced benefits for Seniors. In addition to basic coverage, the plan may offer limited:

- Dental Care
- Hearing Exams
- Podiatry
- Hospice Care

BENEFIT	Kaiser Senior Advantage** You or Your Dependents Pay:
Medicare	Requires Medicare Parts A & B or B only
Maximum Lifetime Coverage	No Dollar Limit
Calendar Year Deductible	No Deductible
Hospital Services	
• Inpatient	$100 Per Admission
• Outpatient	$15 Charge
• No Precertification Review	N/A
Physician Care	
• Office Visits	$15 Per Visit
• Second Opinion	$15 Per Visit
• w/o Second Opinion	N/A
• Well Baby Care	No Charge to 23 Months
• Diagnostic X-rays/Lab	No Charge
• Immunizations	No Charge
Durable Medical Equipment	No Charge
Routine Exams - Adults	
• Annual Physical	$15 Charge
• Prostate Screening	$15 Charge
• Well Women Exams	$15 Charge Note: For well women exams, may self-refer to a Kaiser Provider.
Maternity Care	$100 Per Admission
Prescription Drugs	$10 - Generic Prescription $15 - Brand Prescription Up to 100-Day Supply Dental Prescriptions Included

BENEFIT	Kaiser Senior Advantage** You or Your Dependents Pay:
Chiropratic	$15 Charge Up to 30 Visits Per Year
Eye Refractions	$150 Frame and Lens Allowance Every 24 Months, Exam $15 Charge
Family Planning	
• Contraceptives	$10 Generic $15 Brand
• Vasectomy	$15 Charge
• Tubal Ligation	$15 Charge
• Infertility Services	Limited, $15 Per Visit
Mental Health*	
• Inpatient	$100 Per Admission, Up to 45 days
• Outpatient	$15 Per Visit
• Liftime Maximum	190 days
Alcohol & Drug Abuse	
• Inpatient	$100 Per Admission, Detox Only
• Outpatient	$15 Per Visit
• Maximum Yearly Outpatient	Unlimited
• Lifetime Maximum	N/A
Home Health Care	No Charge
Skilled Nursing Facility	No Charge Up to 100 Days
Emergency Services	$50 Charge – Waived if Admitted
Ambulance	No Charge

This is a general description and overview of Kaiser Senior Advantage Plan.

*Note: The number of days maximum does not apply to certain conditions that are covered same as any other illness in accordance with California Mental Health Parity Act.

**HMO Plans: Designed to provide quality comprehensive medical services, routine and preventive care while controlling costs by using either its own doctors or health care centers or by providing services through contractual arrangements with community health care providers.

Health Plans At-A-Glance

The following chart provides an overview of your health plan options through the County of Orange. *This comparison is intended to give a general description and overview of available plans. See individual plan material for detailed information.*

	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organizations (HMOs)**	
	Premier Wellwise		Premier Sharewell		CIGNA Private Practice	Kaiser
	You or Your Dependent(s) Pay:		You or Your Dependent(s) Pay:		You or Your Dependent(s) Pay:	You or Your Dependent(s) Pay:
BENEFIT	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
Maximum Lifetime Coverage	$1,000,000		$1,000,000		No Dollar Limit	No Dollar Limit
Calendar Year Deductible	$300 Per Individual $600 Per Family		$5,000 Per Family		No Deductible	No Deductible
Hospital Services						
• Inpatient	10%	20%	10%	20%	$100 Per Admission	$100 Per Admission
• Outpatient	10%	20%	10%	20%	$15 Per Visit	$15 Per Visit
• No Precertification Review	40%	40%	40%	40%	N/A	N/A
Physician Care						
• Office Visits	10%	20%	10%	20%	$15 Per Visit	$15 Per Visit
• Second Opinion	10%	20%	10%	20%	$15 Per Visit	$15 Per Visit
• w/o Second Opinion	40%	40%	40%	40%	N/A	N/A
• Well Baby Care	No Charge	Not Covered	No Charge	Not Covered	No Charge	No Charge to 23 months
• Diagnostic X-rays/Lab	10%	20%	10%	20%	No Charge	No Charge
• Immunizations	No Charge (Limited)	Not Covered	No Charge (Limited)	Not Covered	No Charge	No Charge
Routine Exams – Adults • Annual Physical • Prostate Screening • Well Women Exams	No charge up to a maximum annual benefit amount of $250 In-network only (Except $250 annual limit does not apply to specific procedures under "Wellness Benefit" in plan document).	Limited to specific procedures under the "Wellness Benefit." See Plan Document.	No charge up to a maximum annual benefit amount of $250 In-network only (Except $250 annual limit does not apply to specific procedures under "Wellness Benefit" in plan document).	Limited to specific procedures under the "Wellness Benefit." See Plan Document.	$15 Charge $15 Charge $15 Charge Note: Well women exams are for breast and pelvic only; not a complete physical. May self-refer within designated plan medical group	$15 Charge $15 Charge $15 Charge Note: For well women exam, may self-refer to a Kaiser provider
Prescription Drugs	20%	20%	20%	20%	$10 Generic Prescription $15 Brand Prescription 30-Day Supply	$10 Generic Prescription $15 Brand Prescription Up to 100-Day Supply Dental Prescriptions Included
	Drug Card Program					
Maternity Care	10%	20%	10%	20%	$100 Per Admission	$100 Per Admission
Emergency Services	10%	20%	10%	20%	$50 Per Visit Waived if admitted	$50 Per Visit Waived if admitted
Ambulance	20%	20%	20%	20%	No Charge	No Charge

BENEFIT	Preferred Provider Organization (PPO) Plans*				Health Maintenance Organizations (HMOs)**	
	Premier Wellwise		Premier Sharewell		CIGNA Private Practice	Kaiser
	You or Your Dependent(s) Pay:		You or Your Dependent(s) Pay:		You or Your Dependent(s) Pay:	You or Your Dependent(s) Pay:
	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider	HMO Provider	HMO Provider
Family Planning						
• Contraceptives	Not Covered	Not Covered	Not Covered	Not Covered	$10 Generic Prescription $15 Brand Prescription	$10 Generic Prescription $15 Brand Prescription
• Vasectomy	10%	20%	10%	20%	$15 Charge	$15 Charge
• Tubal Ligation	10%	20%	10%	20%	$15 Charge	$15 Charge
• Infertility Services	Not Covered	Not Covered	Not Covered	Not Covered	Limited, $15 Per Visit	Limited, $15 Per Visit
Mental Health						
• Inpatient	10%	20%	10%	20%	$100 Per Admission, Up to 30 Days	$100 Per Admission, Up to 45 Days
• Outpatient	50%	50%	50%	50%	$20 Per Visit	$15 Per Visit
• Maximum Yearly Outpatient	Up to $50 Per Visit 50 Visits		Up to $50 Per Visit 50 Visits		N/A	20 visits per year
• Lifetime Maximum	$30,000 Maximum benefit combined with Alcohol and Substance Abuse below.				N/A	N/A
	Note: The Lifetime and visit maximums do not apply to certain conditions that are covered same as any other illness in accordance with the California Mental Health Parity Act.				**Note:** Lifetime, visit and day maximums do not apply to certain conditions that are covered same as any other illness in accordance with the California Mental Health Parity Act.	**Note:** Lifetime, visit and day maximums do not apply to certain conditions that are covered same as any other illness in accordance with the California Mental Health Parity Act.
Alcohol and Drug Abuse						
• Inpatient	10%	20%	10%	20%	$100 Per Admission	$100 Per Admission, Detox Only
• Outpatient	50%	50%	50%	50%	$15 Per Visit	$15 Per Visit
• Maximum Yearly Outpatient	Up to $50 Per Visit 50 Visits		Up to $50 Per Visit 50 Visits		Detox Only	Unlimited
• Lifetime Maximum	$30,000 Maximum benefit combined with Mental Health above.					N/A
Home Health Care	10%	20%	10%	20%	No Charge	No Charge
Skilled Nursing Facility	Limited (Limited to 60 Days)		Limited (Limited to 60 Days)		No Charge (Up to 60 Days)	No Charge
Eye Refractions	Not Covered		Not Covered		$5 Charge Glasses $10	$15 Charge
Chiropractic	10%	20%	10%	20%	$15 Per Visit	$15 Per Visit
• Frequency Limitations • Yearly Maximum	50 Visits Per Year $1,000 Maximum		50 Visits Per Year $1,000 Maximum		30 Visits Per Year	30 Visits Per Year
Durable Medical Equipment	Covered Contact health plans for further details		Covered		Covered at 100% when prescribed by your Primary Care Physician	Not Covered

***PPO Plans:** Designed to provide freedom to select physicians, specialists, hospitals and other service providers of your personal choice. The PPO plans pay 100% of eligible health care expenses that are in excess of $10,000 per individual per calendar year.

PPO Provider: County PPO Plans use PacifiCare Signature Options℠ (PPO) as its Preferred Provider Organization Network. The network consists of individual physicians, laboratories and hospitals. As part of this network these "preferred providers" have agreed to provide services at rates which are lower than their regular charges. This helps reduce the cost of health care for you, your dependent(s) and the County. You or your dependent(s) pay a lower copayment percentage for PPO network providers. Using a PPO network provider is voluntary. You or your dependent(s) decide whether to use a PPO network provider for health care.

Non-PPO Provider: When you or your dependent choose a health care provider who does not participate in the PacifiCare Signature Options℠ (PPO) Provider Network, you or your dependent pays a higher copayment percentage for non-PPO network providers.

****HMO Plans:** Designed to provide quality comprehensive medical services, routine and preventive care while controlling costs by using either its own doctors or health care centers or by providing services through contractual arrangements with community health care providers.

Important Legal Information

Continuing Your Coverage Under COBRA

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law gives you the right to choose continuation of health care coverage if you and/or your eligible dependents lose County coverage. You may continue health care coverage for up to 18, 29, or 36 months, depending on the situation and who is being covered. You would receive a separate COBRA notification within a couple of weeks of the loss of coverage explaining these rights.

If you think your or your dependents' health care coverage will end because an event occurred causing ineligibility under the plan, there are certain things you must do to continue coverage under COBRA. In some cases, you must notify the County of the event. If COBRA is an option for you, you must make an election and pay for coverage within certain time frames.

If you retire or die, the County will notify you and your dependents of your right to continue health care coverage under COBRA. This notification will explain how COBRA works in detail.

If you divorce, legally separate or your child loses dependent status under a group health plan, you or your covered dependents are responsible for notifying the County within 60 days from the date of these events. The County will then notify your dependents of their right to continue health care coverage under COBRA. This notification will explain how COBRA works in detail. COBRA rights will be forfeited if the County is not notified within 60 days of the qualifying event.

For more information, call COBRA Continuation Services at 1-800-877-7994.

Health Insurance Portability and Accountability Act (HIPAA)

The federal Health Insurance Portability and Accountability Act (HIPAA) imposes certain requirements on group health plans. Under HIPAA, a group health plan:

- Is limited in imposing pre-existing conditions
- Must offer retirees and dependents the opportunity to enroll in the plan outside of Open Enrollment in certain situations
- Can't discriminate on the basis of health status with respect to eligibility for plan participation and premium costs
- Can't impose discriminatory lifetime or annual benefit limitations for participants with mental illness
- Must permit hospital admissions (if otherwise covered by the plan) of at least 48 hours in case of normal deliveries and 96 hours in the case of Cesarean Sections

Under HIPAA, the employer of a self-funded non-federal governmental plan, such as the County's PPO plans, has the option to exempt the PPO plans from any or all of these requirements except for the certification requirement. The County has opted to exempt the PPO plans from HIPAA requirements. Our current plan provisions already provide for hospital admissions of at least 48 hours in the case of normal deliveries and 96 hours in the case of Cesarean Sections and will not be changed as a result of the exemption. A summary of current health plan benefits, copayments, and deductibles is included in this booklet and is not affected by this exemption option.

This exemption from these federal requirements will be in effect for the plan year beginning January 1, 2005, and ending December 31, 2005, and may be renewed for subsequent plan years. The County's HMO plans provided through CIGNA and Kaiser already comply with HIPAA.

Certification of County Group Health Plan Coverage

HIPAA also requires the County to provide certification of coverage for plan participants whenever County health insurance coverage is terminated. This certification will provide evidence of County health insurance coverage and will show the period the subscriber and dependents were covered under the County health plan. If, after the County coverage terminates, a former health plan participant becomes covered under another group health plan that excludes coverage for pre-existing medical conditions, the former plan participant may be required to provide the HIPAA certification when enrolling in his or her new plan.

The HIPAA certification will be mailed by the Benefits Center to the last known address each time coverage is terminated from one of the County's health plans. More information will be included on the HIPAA certification at that time. Retirees who are currently enrolled in a County health plan will not receive certification until coverage in one of the County health plans terminates.

Woman's Health and Cancer Rights Act of 1998

Under the Woman's Health and Cancer Rights Act of 1998, you and your dependents' health plan will not restrict benefits if you or your dependent:

- Receives benefits for a mastectomy
- Elects breast reconstruction in connection with a mastectomy

Benefits will not be restricted provided that the breast reconstruction is in consultation with your or your dependent's physician and may include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas

Benefits for breast reconstruction may be subject to appropriate annual deductibles and coinsurance provisions that are consistent with those established for other benefits under the plan.

Domestic Partner Coverage

The County of Orange offers many of the benefits described in this guide to the domestic partners of eligible employees and retirees. Benefits available to a spouse and eligible dependent children are also available to a domestic partner and his or her eligible dependent children. Coverage may include health care (including prescription drug), dental, Dependent Life Insurance, and Voluntary AD&D coverage.

What Is a Domestic Partnership?

In California, a domestic partnership is established when two people file a Declaration of Domestic Partnership with the Secretary of State and meet a number of legal requirements. The partners must, among other things, share a common residence, be at least 18 years of age, not be blood-related in a way that would prevent them from being married to each other in California, and be of the same sex (unless one of them is over age 62 and at least one of them is eligible for Social Security retirement benefits).

The County also recognizes domestic partnerships that are valid in other states, so long as they are substantially the same as California domestic partnerships.

Enrolling a Domestic Partner

If you want coverage for a domestic partner and/or his or her eligible children, you may elect it the first time you enroll yourself, during any open enrollment period, or within 30 days of establishing your domestic partnership.

To enroll, you must call the Benefits Resource Line and affirm that you have a valid California Declaration of Domestic Partnership or similar document from another state. You may be asked to provide a copy of the document to verify eligibility.

If you and your domestic partner are both benefit-eligible County employees or retirees, you must follow the same rules for dual coverage that apply to married couples working for or retired from the County. Also, the coverage and enrollment/disenrollment rules under the applicable EME, RME, or RMR Program pertain to you (see page 12 of this guide).

Effect on Taxes

If you are not allowed to claim your covered domestic partner and his or her children as dependents on your federal income tax return, you will have to pay federal tax on both the County's contributions and any *before-tax* contributions you make toward the cost of their health care coverage. The value of these contributions will be reported to the IRS as "imputed income." If you prefer, you may elect to make your own contributions on an after-tax basis. After-tax contributions are not taxable as imputed income. County contributions will still be subject to imputed income.

County contributions towards domestic partner coverage are not taxable for California state income tax purposes. You will see imputed income for any before-tax contributions you make towards the cost of your domestic partner's health coverage. Tax laws for other states vary.

You should consult with your tax advisor in connection with the tax effect of domestic partner benefits offered by the County. The County cannot provide you with any tax advice.

For More Information

If you need more information about domestic partner coverage, call the toll-free Benefits Resource Line at 1-866-325-2345 to speak to a Benefits Specialist. Benefits Specialists are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific Standard Time, except holidays.

Helpful Information

You can find answers to most of your questions about benefits and enrollment by contacting the County of Orange Benefits Center. If you need additional information after contacting the Benefits Center, you can contact the plans directly.

For Questions About…	Click or Call…
Benefits or Enrolling	
• Benefits Center Web Site	***www2.benefitsweb.com/countyoforange.html***
• Benefits Resource Line	1-866-325-2345 Benefits Specialists are available Monday through Friday between 7:30 a.m. and 5:30 p.m., Pacific Standard Time, except holidays. 1-800-TDD-TDD4 (833-8334)
• Employee Benefits web site	***www.oc.ca.gov/hr/employeebenefits***
Your Health Plans	
• American Specialty Health Plans (HMO Chiropractic Care)	***www.americanspecialtyhp.com*** 1-800-678-9133 P.O. Box 509002 San Diego, CA 92150-9002
• CIGNA Private Practice Plan HMO	***www.mycigna.com*** 1-800-244-6224 400 North Brand Blvd. Glendale, CA 91209
• PacifiCare Health Plan Administrators (Claims Administrator for the PPO plans and Provider Network)	***www.pacificare.com/ocppo*** 1-800-908-9185 P.O. Box 6076 Cypress, CA 90630-0076
• Kaiser Permanente HMO	***www.kaiserpermanente.org*** 1-800-464-4000
• Kaiser Senior Advantage	***www.kaiserpermanente.org*** 1-800-443-0815 Kaiser California Service Center P.O. Box 232400 San Diego, CA 92193
Prescription Drugs	
• Caremark, Inc. (For the Premier Wellwise PPO plan)	***www.caremark.com*** 1-866-212-4758 P. O. Box 686005 San Antonio, TX 78268-6005
Vision Plan	
• Vision Service Plan (CIGNA HMO)	***www.vsp.com*** 1-800-877-7195 P. O. Box 997105 Sacramento, CA 95899-7105
Retirement Benefits	
• Orange County Employees Retirement System (OCERS)	***www.ocers.org*** 1-888-570-6277 2223 Wellington Ave. Santa Ana, CA 92701
• Social Security Administration (Medicare Coverage)	1-800-772-1213

COBRA	
• COBRA Continuation Services	***www.ceridian-benefits.com*** 1-800-877-7994 3201 34th Street South Petersburg, FL 33711
Billing	
• Benefits Billing Services	***www.ceridian-benefits.com*** 1-877–588-0946 3201 34th Street South Petersburg, FL 33711

Network Directories Online

You can view network directories for the health plans on the Internet.

To view network directories for…	Go to…
CIGNA Private Practice HMO Plan	***www.mycigna.com***
Kaiser Permanente HMO Plan Kaiser Senior Advantage Plan	***www.kaiserpermanente.org***
Premier Wellwise Plan	***www.pacificare.com/ocppo***
Premier Sharewell Plan	***www.pacificare.com/ocppo***

The information in this enrollment guide is only an overview of employee benefit plans available to you. The plan documents and insurance policies for each plan provide the detailed, legal information about your coverage. If there is any difference between this guide and the plan documents or insurance policies, the plan documents and insurance policies will govern.

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